

## § 457.960

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

### § 457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect the enrollee's eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and

(b) Promptly redetermine eligibility when the State has information about these changes.

### § 457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for CHIP.

### § 457.980 Verification of enrollment and provider services received.

The State must establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

[66 FR 2685, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

### § 457.985 Integrity of professional advice to enrollees.

The State must ensure through its contracts for coverage and services that its contractors comply with—

(a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and

(b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and informa-

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tion disclosure requirements related to those physician incentive plans, respectively.

### § 457.990 Provider and supplier screening, oversight, and reporting requirements.

The following provisions and their corresponding regulations apply to a State under title XXI of the Act, in the same manner as these provisions and regulations apply to a State under title XIX of the Act:

(a) Part 455, Subpart E, of this chapter.

(b) Sections 1902(a)(77) and 1902(kk) of the Act pertaining to provider and supplier screening, oversight, and reporting requirements.

[76 FR 5970, Feb. 2, 2011]

## Subpart J—Allowable Waivers: General Provisions

SOURCE: 66 FR 2686, Jan. 11, 2001, unless otherwise noted.

### § 457.1000 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements to permit a State to exceed the 10 percent cost limit on expenditures other than benefit expenditures; and

(2) Section 2105(c)(3) of the Act, which permits the purchase of family coverage.

(b) *Scope.* This subpart sets forth requirements for obtaining a waiver under title XXI.

(c) *Applicability.* This subpart applies to separate child health programs; and applies to Medicaid expansion programs when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

[66 FR 2686, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]